

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040923</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Lexington of Wheeling</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>730 W. Hintz Road</u> <u>Wheeling</u> <u>60090</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(847) 537-7474</u> Fax # <u>(847) 537-7599</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>																									
IDPA ID Number: <u>363885225001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>05/12/95</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>221</u>	Skilled (SNF)	<u>221</u>	<u>80,665</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>221</u>	TOTALS	<u>221</u>	<u>80,665</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>27,909</u>	<u>6,856</u>	<u>11,372</u>	<u>46,137</u>	8
9	SNF/PED					9
10	ICF	<u>16,109</u>	<u>1,480</u>	<u>1,662</u>	<u>19,251</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,018</u>	<u>8,336</u>	<u>13,034</u>	<u>65,388</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.06%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/12/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New ConstructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 58 and days of care provided 5,244Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	300,690	35,598	12,483	348,771		348,771		348,771			1
2	Food Purchase		274,318		274,318		274,318	(12,273)	262,045			2
3	Housekeeping	289,286	38,795		328,081		328,081	760	328,841			3
4	Laundry	53,884	24,882		78,766		78,766	(1,045)	77,721			4
5	Heat and Other Utilities			141,118	141,118		141,118	4,062	145,180			5
6	Maintenance	62,133		101,063	163,196		163,196	1,118	164,314			6
7	Other (specify):*											7
8	TOTAL General Services	705,993	373,593	254,664	1,334,250		1,334,250	(7,378)	1,326,872			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,273,764	217,276	2,500	3,493,540		3,493,540		3,493,540			10
10a	Therapy			645,619	645,619		645,619		645,619			10a
11	Activities	164,050	16,819	3,807	184,676		184,676		184,676			11
12	Social Services	59,986		2,411	62,397		62,397		62,397			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,497,800	234,095	678,337	4,410,232		4,410,232		4,410,232			16
	C. General Administration											
17	Administrative	195,319		380,690	576,009		576,009	(380,690)	195,319			17
18	Directors Fees											18
19	Professional Services			65,662	65,662		65,662	9,539	75,201			19
20	Dues, Fees, Subscriptions & Promotions			33,265	33,265		33,265	1,741	35,006			20
21	Clerical & General Office Expenses	470,396	33,437	22,497	526,330		526,330	23,380	549,710			21
22	Employee Benefits & Payroll Taxes			575,518	575,518		575,518	71,902	647,420			22
23	Inservice Training & Education			2,427	2,427		2,427		2,427			23
24	Travel and Seminar			3,689	3,689		3,689	3,189	6,878			24
25	Other Admin. Staff Transportation			337	337		337	10,458	10,795			25
26	Insurance-Prop.Liab.Malpractice			199,224	199,224		199,224	3,475	202,699			26
27	Other (specify):*											27
28	TOTAL General Administration	665,715	33,437	1,283,309	1,982,461		1,982,461	(257,006)	1,725,455			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,869,508	641,125	2,216,310	7,726,943		7,726,943	(264,384)	7,462,559			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,007	31,007		31,007	234,369	265,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			803	803		803	406,467	407,270			32
33	Real Estate Taxes							388,630	388,630			33
34	Rent-Facility & Grounds			1,579,001	1,579,001		1,579,001	(1,579,001)				34
35	Rent-Equipment & Vehicles			2,850	2,850		2,850	4,802	7,652			35
36	Other (specify):*											36
37	TOTAL Ownership			1,613,661	1,613,661		1,613,661	(544,733)	1,068,928			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,236	24,479	140,715		140,715		140,715			39
40	Barber and Beauty Shops			30,442	30,442		30,442		30,442			40
41	Coffee and Gift Shops			2,659	2,659		2,659		2,659			41
42	Provider Participation Fee			120,997	120,997		120,997		120,997			42
43	Other (specify):* Nonallowable Costs			219,839	219,839		219,839	(219,839)				43
44	TOTAL Special Cost Centers		116,236	398,416	514,652		514,652	(219,839)	294,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,869,508	757,361	4,228,387	9,855,256		9,855,256	(1,028,956)	8,826,300			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/02

Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Reference	OHF USE ONLY	
1	Day Care	\$		1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(140)	2	4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients	(1,045)	4	8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(1,107)	43	13
14	Non-Care Related Interest	(803)	32	14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions	(70)	43	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(200,788)	43	24
25	Fund Raising, Advertising and Promotional	(17,566)	43	25
26	Income Taxes and Illinois Personal			26
27	Property Replacement Tax			27
28	Nurse Aide Training for Non-Employees			28
29	Yellow Page Advertising			29
29	Other-Attach Schedule See attached Schedule A	(7,335)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,854)	\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(800,102)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (800,102)	36
37	(sum of SUBTOTALS (A) and (B))	\$ (1,028,956)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x	\$		38
39					39
40	Gift and Coffee Shops	x			40
41	Barber and Beauty Shops	x			41
42	Laboratory and Radiology	x			42
43	Prescription Drugs	x			43
44	Exceptional Care Program	x			44
45	Other-Attach Schedule	x			45
46	Other-Attach Schedule	x			46
47	TOTAL (C): (sum of lines 38-46)		\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Wheeling
Provider # 0040923
1/1/02 - 12/31/02

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections and out of period legal fees	(5,104)	19
Nonallowable Chamber of commerce dues	(280)	20
Nonallowable dentist fee	(308)	43
Offset miscellaneous income	(477)	21
Nonallowable miscellaneous expense	(1,166)	21
Total	<u>(7,335)</u>	

See Accountants' Compilation Report

Lexington of WheelingID# 0040923Report Period Beginning: 01/01/02Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(140)	0	0	0	0	0	0	0	0	0	0	(140)	2
3	Housekeeping	0	0	760	0	0	0	0	0	0	0	0	760	3
4	Laundry	(1,045)	0	0	0	0	0	0	0	0	0	0	(1,045)	4
5	Heat and Other Utilities	0	0	4,062	0	0	0	0	0	0	0	0	4,062	5
6	Maintenance	0	0	1,118	0	0	0	0	0	0	0	0	1,118	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,185)	0	5,940	0	0	0	0	0	0	0	0	4,755	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(380,690)	0	0	0	0	0	0	0	(380,690)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,452	10,537	0	0	0	0	0	0	0	0	21,989	19
20	Fees, Subscriptions & Promotions	0	0	2,021	0	0	0	0	0	0	0	0	2,021	20
21	Clerical & General Office Expenses	0	75	24,948	0	0	0	0	0	0	0	0	25,023	21
22	Employee Benefits & Payroll Taxes	0	0	59,769	0	0	0	0	0	0	0	0	59,769	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,189	0	0	0	0	0	0	0	0	3,189	24
25	Other Admin. Staff Transportation	0	0	0	10,458	0	0	0	0	0	0	0	10,458	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,475	0	0	0	0	0	0	0	3,475	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	11,527	100,464	(366,757)	0	0	0	0	0	0	0	(254,766)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,185)	11,527	106,404	(366,757)	0	0	0	0	0	0	0	(250,011)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	206,195	0	28,174	0	0	0	0	0	0	0	234,369	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(803)	402,711	0	4,559	0	0	0	0	0	0	0	406,467	32
33	Real Estate Taxes	0	379,001	0	2,283	0	0	0	0	0	0	0	381,284	33
34	Rent-Facility & Grounds	0	(1,579,001)	0	0	0	0	0	0	0	0	0	(1,579,001)	34
35	Rent-Equipment & Vehicles	0	0	0	4,802	0	0	0	0	0	0	0	4,802	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(803)	(591,094)	0	39,818	0	0	0	0	0	0	0	(552,079)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(219,531)	0	0	0	0	0	0	0	0	0	0	(219,531)	43
44	TOTAL Special Cost Centers	(219,531)	0	0	0	0	0	0	0	0	0	0	(219,531)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(221,519)	(579,567)	106,404	(326,939)	0	0	0	0	0	0	0	(1,021,621)	45

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33%	See attached Schedule B		Lexington Health		
John Samatas Discretionary Trust	33.33%			Care Systems of		
Cynthia Thiem Discretionary Trust	33.34%			Wheeling Ltd. Ptsp.		Lessor
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 Professional fee	\$	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	\$ 11,452	\$ 11,452 1
2	V	21 Bank charges		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75 2
3	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	206,195	206,195 3
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653 4
5	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	399,058	399,058 5
6	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	379,001	379,001 6
7	V	34 Rental expense	1,579,001	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,579,001) 7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V	**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.					13
14	Total		\$ 1,579,001			\$ 999,434	\$ * (579,567) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.

Provider # 0040923

1/1/02 - 12/31/02

Schedule B

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.

Lombard

Lexington Health Care Center of Bloomingdale, Inc.

Bloomingdale

Lexington Health Care Center of Elmhurst, Inc.

Elmhurst

Lexington Health Care Center of LaGrange, Inc.

LaGrange

Lexington Health Care Center of Lake Zurich, Inc.

Lake Zurich

Lexington Health Care Center of Schaumburg, Inc.

Schaumburg

Lexington Health Care Center of Chicago Ridge, Inc.

Chicago Ridge

Lexington Health Care Center of Streamwood, Inc.

Streamwood

Lexington Health Care Center of Orland Park, Inc.

Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 760	\$ 760
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,869	3,869
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	193	193
18	V	6 Repairs & maintenance		Royal Management Corp.	**	1,054	1,054
19	V	6 Scavenger & exterminating		Royal Management Corp.	**	48	48
20	V	6 Security service		Royal Management Corp.	**	16	16
21	V	19 Computer consultant & supplies		Royal Management Corp.	**	8,395	8,395
22	V	19 Professional fees		Royal Management Corp.	**	2,142	2,142
23	V	20 Advertising - help wanted		Royal Management Corp.	**	1,215	1,215
24	V	20 Dues & subscriptions		Royal Management Corp.	**	806	806
25	V	21 Bank charges		Royal Management Corp.	**	2,801	2,801
26	V	21 Communications		Royal Management Corp.	**	560	560
27	V	21 Office supplies & printing		Royal Management Corp.	**	10,613	10,613
28	V	21 Postage		Royal Management Corp.	**	3,333	3,333
29	V	21 Telephone		Royal Management Corp.	**	7,641	7,641
30	V	22 FICA		Royal Management Corp.	**	32,216	32,216
31	V	22 FUTA		Royal Management Corp.	**	593	593
32	V	22 SUTA		Royal Management Corp.	**	646	646
33	V	22 Insurance - W/C		Royal Management Corp.	**	747	747
34	V	22 Insurance - hospitalization		Royal Management Corp.	**	18,740	18,740
35	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	6,827	6,827
36	V	24 Travel & seminar		Royal Management Corp.	**	3,189	3,189
37	V						
38	V	**Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 106,404	\$ * 106,404

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 10,458	\$ 10,458
16	V	26 Insurance - general		Royal Management Corp.	**	3,475	3,475
17	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,730	3,730
18	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	7,326	7,326
19	V	30 Depreciation - equipment		Royal Management Corp.	**	17,118	17,118
20	V	32 Interest		Royal Management Corp.	**	4,559	4,559
21	V	33 Property taxes		Royal Management Corp.	**	2,283	2,283
22	V	35 Equipment rental		Royal Management Corp.	**	4,802	4,802
23	V	17 Management fees	380,690	Royal Management Corp.	**		(380,690)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	**Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 380,690			\$ 53,751	\$ * (326,939)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	11.00%	Salary	\$ 39,367	L17, C1	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule C	2	10.00%	Salary	17,496	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	10.00%	Salary	21,870	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10.00%	Salary	5,249	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	10.00%	Salary	13,258	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 97,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Wheeling
Provider #0040923
1/1/02 - 12/31/02

Schedule C

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Total	142,504	320,633	178,130	42,751	107,973	791,991

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	\$ 6,954	\$ 80,665	\$ 760	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380	80,665	3,869	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765	80,665	193	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640	80,665	1,054	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438	80,665	48	5
6	6	Security service	Bed Days	737,665	10	150	80,665	16	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767	80,665	8,395	7
8	19	Professional fees	Bed Days	737,665	10	19,590	80,665	2,142	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111	80,665	1,215	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373	80,665	806	10
11	21	Bank charges	Bed Days	737,665	10	25,613	80,665	2,801	11
12	21	Communications	Bed Days	737,665	10	5,118	80,665	560	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051	80,665	10,613	13
14	21	Postage	Bed Days	737,665	10	30,484	80,665	3,333	14
15	21	Telephone	Bed Days	737,665	10	69,873	80,665	7,641	15
16	22	FICA	Bed Days	737,665	10	294,613	80,665	32,216	16
17	22	FUTA	Bed Days	737,665	10	5,419	80,665	593	17
18	22	SUTA	Bed Days	737,665	10	5,907	80,665	646	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829	80,665	747	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371	80,665	18,740	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427	80,665	6,827	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161	80,665	3,189	22
23									23
24									24
25	TOTALS				\$ 973,034	\$		\$ 106,404	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	\$ 95,636	\$ 80,665	\$ 10,458	1
2	26	Insurance - general	Bed Days	737,665	10	31,776	80,665	3,475	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112	80,665	3,730	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995	80,665	7,326	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541	80,665	17,118	5
6	32	Interest	Bed Days	737,665	10	41,692	80,665	4,559	6
7	33	Property taxes	Bed Days	737,665	10	20,881	80,665	2,283	7
8	35	Equipment rental	Bed Days	737,665	10	43,917	80,665	4,802	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 491,550	\$	\$ 53,751	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lexington Financial						\$				\$	1	
2	Services II, L.L.C.	x		Mortgage	\$49,514.00	12/29/98	6,513,000	5,821,915	12/29/08	0.0675	399,058	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Shareholders	x		Working Capital	None	Various	587,000	300,000	Demand	0.0300	803	6	
7												7	
8												8	
9	TOTAL Facility Related				\$49,514.00		\$ 7,100,000	\$ 6,121,915			\$ 399,861	9	
	B. Non-Facility Related*												
10								Amortization of loan costs			3,653	10	
11								Interest income offset			(803)	11	
12								Allocated from management company				4,559	12
13												13	
14	TOTAL Non-Facility Related						\$				\$ 7,409	14	
15	TOTALS (line 9+line14)						\$ 7,100,000	\$ 6,121,915			\$ 407,270	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/02Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	396,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		Allocated from management company	\$	2,283	
		2001	\$	379,253	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(14,464)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	396,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	7,346	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ (252) For 1995 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(252)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	388,630	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1997	375,879	8
	1998	365,183	9
	1999	373,589	10
	2000	379,331	11
	2001	379,253	12

2001 taxes:	379,253		
Estimated increase:	1,045		
Estimated 2002 taxes:	396,319		
Use:	396,000		

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4700

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-10-401-027-0000</u>	<u>Land & Building</u>	\$ <u>379,253.00</u>	\$ <u>379,253.00</u>
2. <u>Royal Management Corp. (Omni Partners)</u>		\$ _____	\$ _____
3. <u>06-19-201-018</u>	<u>Land & Building</u>	\$ <u>70,162.00</u>	\$ <u>160.00</u>
4. <u>Royal Management Corp. (Samvest)</u>		\$ _____	\$ _____
5. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>144,399.00</u>	\$ <u>2,123.00</u>
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u>593,814.00</u>	\$ <u>381,536.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	137,650	1993	\$ 595,000	1
2	Mgmt Co.		2002	17,803	2
3	TOTALS	137,650		\$ 612,803	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	211	1995	1995	\$ 6,537,447	\$	10-40	\$ 164,075	\$ 164,075	\$ 1,251,075
5	10	2000	2000	98,710	1,234	40	2,468	1,234	6,170
6									
7									
8									
Improvement Type**									
9	Building improvement	1995		3,587		15	239	239	1,824
10	Land improvement - sidewalk replacemen	1996		1,927	128	15	128		834
11	Leasehold improvement - pines & soc	1996		3,432	229	15	229		1,488
12	Basement rehab	1997		18,611	1,860	10	1,860		10,233
13	Building improvement - curtains/track	1997		1,936		35	55	55	304
14	Landscaping	1997		2,002	134	15	134		736
15	Wiring for MDS	1998		3,552	355	10	355		1,598
16	Parking Lot	1998		2,952	294	10	294		1,325
17	Roof repair	2000		1,980	198	10	198		495
18	Remodel HVAC/exhaust system - office area	2000		7,480	374	20	374		935
19	Automatic Door	2000		1,300	130	10	130		325
20	Rods for beside curtains	2000		2,525	252	10	252		630
21	Floor tile	2000		10,298	1,030	10	1,030		2,575
22	Parking lot seal coating and repair	2001		2,177	218	10	218		327
23	Infrared curtain units for 3 elevators	2001		4,500	900	5	900		1,350
24	Boiler vent repairs	2001		3,084	308	10	308		462
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Leasehold improvements - management company	1995	\$ 11,284	\$	35	\$ 409	\$ 409	\$ 2,418	37	
38	Leasehold improvements - management company	1996	9,183		35	333	333	1,706	38	
39	Leasehold improvements - management company	1989	317		31	12	12	149	39	
40	HVAC - management company	1998	238		35	9	9	34	40	
41	Offices - management company	1999	600		35	22	22	60	41	
42	Offices - management company	2000	285		35	10	10	22	42	
43	Land improvements - management company	2002	10,679		15	653	653	653	43	
44	Building - management company	2002	248,961		40	5,705	5,705	5,705	44	
45	Sewer & water improvements - management company	2002	5,663		30	173	173	173	45	
46									46	
47									47	
48									48	
49									49	
50									50	
51									51	
52									52	
53									53	
54									54	
55									55	
56									56	
57									57	
58									58	
59									59	
60									60	
61									61	
62									62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 6,994,710	\$ 7,644		\$ 180,573	\$ 172,929	\$ 1,293,606	70	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 564,640	\$ 23,363	\$ 63,955	\$ 40,592	5-10 years	\$ 401,445	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from management company	170,969		17,118	17,118		44,719	74
75	TOTALS	\$ 735,609	\$ 23,363	\$ 81,073	\$ 57,710		\$ 446,164	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			33,390		3,730	3,730		23,235	79
80	TOTALS			\$ 33,390	\$	\$ 3,730	\$ 3,730		\$ 23,235	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,376,512	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,007	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 265,376	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 234,369	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,763,005	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: _____

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 7,652 Description: Postage meter -\$420 ; Copier \$2,430 \$; Allocated from management - \$4,802
(Attach a schedule detailing the breakdown of movable equipment)

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. **/2003** §

13. /2004 \$

14. /2005 \$

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	19,490	\$ 251,966	\$	19,490	\$ 251,966	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		8,529	58,160		8,529	58,160	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		25,445	335,493		25,445	335,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				116,236		116,236	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): See attached Schedule D					24,479			24,479	13
14	TOTAL			\$	53,464	\$ 670,098	\$ 116,236	53,464	\$ 786,334	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Wheeling

Provider #: 0040923

01/01/02 to 12/31/02

Schedule D

Schedule XIV. Special Services

Line 13, Other

<u>Service</u>	<u>Cost</u>	<u>Line Reference</u>
Clinitron Beds	3,357	L 39, C 3
Oxygen	17,688	L 39, C 3
Laboratory	2,134	L 39, C 3
Radiology	1,300	L 39, C 3
Total	<u>24,479</u>	

See Accountants' Compilation Report

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 144,948	\$ 164,206	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 632,868)	2,193,349	2,193,349	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,883	76,883	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	32,238	32,238	8
9	Other(specify): See attached Schedule E		172,244	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,447,418	\$ 2,638,920	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,128	8,128	12
13	Land		612,803	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	164,530	465,784	15
16	Equipment, at Historical Cost	146,378	768,999	16
17	Accumulated Depreciation (book methods)	(119,241)	(1,763,005)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		58,443	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 199,795	\$ 6,680,078	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,647,213	\$ 9,318,998	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 303,692	\$ 303,692	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	515,445	515,445	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	284,212	284,212	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,642	2,642	31
32	Accrued Real Estate Taxes(Sch.IX-B)		396,000	32
33	Accrued Interest Payable		32,748	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	547,439	252,226	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,953,430	\$ 2,086,965	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,821,915	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,821,915	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,953,430	\$ 7,908,880	46
47	TOTAL EQUITY (page 18, line 24)	\$ 693,783	\$ 1,410,118	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,647,213	\$ 9,318,998	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington of Wheeling**Provider # 0040923****1/1/02 - 12/31/02****Schedule E**

XV. Balance Sheet

A. Current Assets

9. Other Current Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Escrow		172,244
Total line 9		172,244

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	295,212	-
Accrued management fees	164,370	164,370
Accrued 401 (k) contribution	19,740	19,740
Due to related parties	412	412
Other accrued expenses	67,705	67,704
Total line 36	547,439	252,226

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Routine Services - Private Bedhold	2,228
Miscellaneous Income	477
Investment Income in Lexington Financial Services, LLC II	1,020
Total line 28	3,725

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,776,438	1
2	Restatements (describe):		2
3	Prior period adjustment	(103,880)	3
4	Prior year post closing entries	(144,888)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,527,670	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(443,887)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(390,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (833,887)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 693,783	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,486,632	1
2	Discounts and Allowances for all Levels	(417,425)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,069,207	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,106,715	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,106,715	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,807	12
13	Barber and Beauty Care	38,342	13
14	Non-Patient Meals	140	14
15	Telephone, Television and Radio	112	15
16	Rental of Facility Space		16
17	Sale of Drugs	137,552	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,352	19
20	Radiology and X-Ray	1,855	20
21	Other Medical Services	35,868	21
22	Laundry	1,045	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 231,073	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	649	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 649	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	3,725	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,725	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,411,369	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,334,250	31
32	Health Care	4,410,232	32
33	General Administration	1,982,461	33
B. Capital Expense			
34	Ownership	1,613,661	34
C. Ancillary Expense			
35	Special Cost Centers	393,655	35
36	Provider Participation Fee	120,997	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,855,256	40
41	Income before Income Taxes (line 30 minus line 40)**	(443,887)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (443,887)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/02Ending: 12/31/02

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 85,524	\$ 41.12	1
2	Assistant Director of Nursing	4,133	4,197	114,079	27.18	2
3	Registered Nurses	48,973	52,199	1,384,687	26.53	3
4	Licensed Practical Nurses	9,860	10,532	243,237	23.10	4
5	Nurse Aides & Orderlies	103,461	108,223	1,380,148	12.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,145	5,464	66,089	12.10	8
9	Activity Director	1,952	2,016	28,412	14.09	9
10	Activity Assistants	14,299	14,863	135,638	9.13	10
11	Social Service Workers	3,251	3,299	59,986	18.18	11
12	Dietician					12
13	Food Service Supervisor	1,849	1,849	27,804	15.04	13
14	Head Cook	2,010	2,090	23,195	11.10	14
15	Cook Helpers/Assistants	16,097	16,780	144,089	8.59	15
16	Dishwashers	16,860	17,277	105,602	6.11	16
17	Maintenance Workers	3,572	3,747	62,133	16.58	17
18	Housekeepers	39,498	42,066	289,286	6.88	18
19	Laundry	7,848	8,402	53,884	6.41	19
20	Administrator	2,000	2,080	98,079	47.15	20
21	Assistant Administrator					21
22	Other Administrative	728	728	97,240	133.57	22
23	Office Manager					23
24	Clerical	24,653	26,249	470,396	17.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,189	324,141	\$ 4,869,508 *	\$ 15.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	242	\$ 12,483	L1, C3	35
36	Medical Director	12	24,000	L9, C3	36
37	Medical Records Consultant	26	1,300	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	81	3,807	L11, C3	44
45	Social Service Consultant	51	2,411	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	412	\$ 45,201		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of Wheeling**# **0040923**Report Period Beginning: **01/01/02**Ending: **12/31/02****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership %	Amount	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function			Description	Amount	Description	Amount
Debbie Randon	Administrator	0.00%	\$ 71,598	Workers' Compensation Insurance	\$ 89,256	IDPH License Fee	\$
Anne Donos	Administrator	0.00%	26,481	Unemployment Compensation Insurance	21,324	Advertising: Employee Recruitment	31,181
James Samatas	Administrative	33.33%	39,367	FICA Taxes	356,832	Health Care Worker Background Check	
John Samatas	Admin/Plant Ops	33.33%	17,496	Employee Health Insurance	133,275	(Indicate # of checks performed <u>10</u>)	120
Cynthia Thiem	Administrative	33.34%	21,870	Employee Meals	12,133	Miscellaneous Dues & Subs	1,241
George Samatas	Administrative	0.00%	5,249	Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,658
Jason Samatas	Administrative	0.00%	13,258	401(k) Contribution	23,070		
TOTAL (agree to Schedule V, line 17, col. 1)				Other employee benefits	11,530		
(List each licensed administrator separately.)			\$ 195,319				
B. Administrative - Other							
Description		Amount					
Management fees (eliminated in column 7)		\$ 380,690				Allocated from management company	806
						Less: Public Relations Expense	()
						Non-allowable advertising	()
						Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 380,690	TOTAL (agree to Schedule V, line 22, col.8)	\$ 647,420	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,006
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting	\$ 14,515			\$	Out-of-State Travel	\$
American Express Tax & Bus. Svs.	Accounting	5,468					
Freedman, Anselmo & Lindberg	Collections	1,625	N/A			In-State Travel	
Global Care	Consulting	3,060					
Harris, Kessler & Goldstein	Legal	4,178					
ING	401(k) Administration	645				Seminar Expense	3,689
James Samatas	Legal	77					
Personnel Planners	U/C Consulting	1,095				Allocated from management company	3,189
Sachnoff and Weaver	Legal	26,568				Entertainment Expense	()
Systematic Management Systems	Billing Consulting	1,130				(agree to Sch. V, line 24, col. 8)	
See attached Schedule F		7,301				TOTAL	\$ 6,878
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 65,662				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington of Wheeling
Provider # 0040923
1/1/02 - 12/31/02

Schedule F

XIX. Support Schedules
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Katten, Muchin, Zavis and Rosenman	Legal	868
Carol Jescke	Staffing consultant	739
Glantz - Richman	Rehabilitation consultant	350
Internet Presence Consulting	Computer consulting	711
Advanced Answers on Demand, Inc	Computer consulting	3,247
Information Control, Inc.	Computer consulting	867
Gigatrend	Computer consulting	195
Action Computer Services	Computer consulting	324
		<u>7,301</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>65,662</u>
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	798
Brekke Consulting, Inc.	Exec. Counsel Consulting	184
Gilson, Labus and Silverman	Accounting	50
James Samatas	Legal	22
Katten, Muchin, Zavis and Rosenman	Legal	242
Sachnoff and Weaver	Legal	132
ING / Pension Administrators / Aetna Life Insurance & Annuity	401 (k) Administration	591
Various	Consulting	123
Various	Computer Consulting	8,395
Allocated from building partnership		
James Samatas	Filing and recording fees	106
McCracken, Walsh, de Lavan	Real estate tax appeal fees	7,346
LaSalle Appraisal Group, Inc.	Appraisal fees	4,000
Reclassifications		
McCracken, Walsh, de Lavan	Real estate tax appeal fees	(7,346)
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(1,625)
Global Care	Consulting-out of period	(3,060)
Sachnoff & Weaver	Legal-out of period	(419)
Total, Agrees to Schedule V, Line 19, Column 8		<u>75,201</u>

See Accountants' Compilation Report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4							N/A						
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number <u>Lexington of Wheeling</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>7.5 years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>64,301</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>120,997</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0040923</u> Report Period Beginning: <u>01/01/02</u> Ending: <u>12/31/02</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ <u>12,133</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>140</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0%</u> d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>N/A</u> If no, please explain. <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

Lexington of Wheeling

03:23 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,028,956	equal to	-1,028,956	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	407,270	equal to	407,270	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	388,630	equal to	388,630	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	265,376	equal to	265,376	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,652	equal to	7,652	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	645,619	equal to	645,619	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	116,236	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,334,250	equal to	1,334,250	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,410,232	equal to	4,410,232	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,982,461	equal to	1,982,461	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,613,661	equal to	1,613,661	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	393,655	equal to	393,655	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	120,997	equal to	120,997	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,207,675	equal to	3,273,764	-66,089	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	164,050	equal to	164,050	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	59,986	equal to	59,986	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	300,690	equal to	300,690	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	62,133	equal to	62,133	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	289,286	equal to	289,286	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	53,884	equal to	53,884	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	195,319	equal to	195,319	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	470,396	equal to	470,396	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,869,508	equal to	4,869,508	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	12,483	< or = to	12,483	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,500	< or = to	2,500	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,807	< or = to	3,807	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,411	< or = to	2,411	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	195,319	equal to	195,319	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	380,690	equal to	380,690	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	65,662	equal to	65,662	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	647,420	equal to	647,420	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	35,006	equal to	35,006	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,878	equal to	6,878	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	120,997	equal to	120,997	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	12,133	< or = to	71,902	-59,769	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	12,133	equal to	12,133	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,244	equal to	11,372	-6,128	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-800,102	equal to	-800,102	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	6,121,915	equal to	6,121,915	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	396,000	equal to	396,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	612,803	equal to	612,803	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,994,710	equal to	6,994,710	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	768,999	equal to	768,999	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,763,005	equal to	1,763,005	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	693,783	equal to	693,783	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-443,887	equal to	-443,887	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,647,213	equal to	2,647,213	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	300,690	35,598	12,483	348,771	0	348,771	0	348,771
2. Food P	0	274,318	0	274,318	0	274,318	-12,273	262,045
3. Housek	289,286	38,795	0	328,081	0	328,081	760	328,841
4. Laundry	53,884	24,882	0	78,766	0	78,766	-1,045	77,721
5. Heat ar	0	0	141,118	141,118	0	141,118	4,062	145,180
6. Mainte	62,133	0	101,063	163,196	0	163,196	1,118	164,314
7. Other (	0	0	0	0	0	0	0	0
8. Total G	705,993	373,593	254,664	1,334,250	0	1,334,250	-7,378	1,326,872
9. Medical	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursin	3,273,764	217,276	2,500	3,493,540	0	3,493,540	0	3,493,540
10a. Ther	0	0	645,619	645,619	0	645,619	0	645,619
11. Activi	164,050	16,819	3,807	184,676	0	184,676	0	184,676
12. Social	59,986	0	2,411	62,397	0	62,397	0	62,397
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	3,497,800	234,095	678,337	4,410,232	0	4,410,232	0	4,410,232
17. Admin	195,319	0	380,690	576,009	0	576,009	-380,690	195,319
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	65,662	65,662	0	65,662	9,539	75,201
20. Fees,	0	0	33,265	33,265	0	33,265	1,741	35,006
21. Cleric	470,396	33,437	22,497	526,330	0	526,330	23,380	549,710
22. Emplo	0	0	575,518	575,518	0	575,518	71,902	647,420
23. Inserv	0	0	2,427	2,427	0	2,427	0	2,427
24. Travel	0	0	3,689	3,689	0	3,689	3,189	6,878
25. Other	0	0	337	337	0	337	10,458	10,795
26. Insura	0	0	199,224	199,224	0	199,224	3,475	202,699
27. Other	0	0	0	0	0	0	0	0
28. Total C	665,715	33,437	1,283,309	1,982,461	0	1,982,461	-257,006	1,725,455
29. Total C	4,869,508	641,125	2,216,310	7,726,943	0	7,726,943	-264,384	7,462,559
30. Depre	0	0	31,007	31,007	0	31,007	234,369	265,376
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	803	803	0	803	406,467	407,270
33. Real E	0	0	0	0	0	0	388,630	388,630
34. Rent -	0	0	1,579,001	1,579,001	0	1,579,001	#####	0
35. Rent -	0	0	2,850	2,850	0	2,850	4,802	7,652
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	1,613,661	1,613,661	0	1,613,661	-544,733	1,068,928
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	116,236	24,479	140,715	0	140,715	0	140,715
40. Barbe	0	0	30,442	30,442	0	30,442	0	30,442
41. Coffee	0	0	2,659	2,659	0	2,659	0	2,659
42. Provid	0	0	120,997	120,997	0	120,997	0	120,997
43. Other	0	0	219,839	219,839	0	219,839	-219,839	0
44. Total S	0	116,236	398,416	514,652	0	514,652	-219,839	294,813
45. Grand	4,869,508	757,361	4,228,387	9,855,256	0	9,855,256	#####	8,826,300

	After	
General Service Cost Center	Operating	Consolidation
1. Cash on	144,948	164,206
2. Cash - F	0	0
3. Account	2,193,349	2,193,349
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	76,883	76,883
7. Other Pi	0	0
8. Account	32,238	32,238
9. Other (s	0	172,244
10. Total c	2,447,418	2,638,920
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	8,128	8,128
13. Land	0	612,803
14. Buildin	0	6,528,926
15. Lease	164,530	465,784
16. Equipn	146,378	768,999
17. Accum	-119,241	-1,763,005
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (:	0	58,443
24. Total L	199,795	6,680,078
25. Total A	2,647,213	9,318,998
CURRENT LIABILITIES		
26. Accour	303,692	303,692
27. Officer	0	0
28. Accour	515,445	515,445
29. Short-T	300,000	300,000
30. Accrue	284,212	284,212
31. Accrue	2,642	2,642
32. Accrue	0	396,000
33. Accrue	0	32,748
34. Deferre	0	0
35. Federa	0	0
36. Other (	547,439	252,226
37. Other (	0	0
38. Total C	1,953,430	2,086,965
LONG TERM LIABILITES		
39. Long-T	0	5,821,915
40. Mortga	0	0
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	0	5,821,915
46. Total Li	1,953,430	7,908,880
47. Total Ei	693,783	1,410,118
48. Total Li	2,647,213	9,318,998

Balance per
Medicaid
Trial Balance

1. Gross F 8,486,632
2. Discour -417,425

Subtota 8,069,207
4. Day Ca 0
5. Other C 0
6. Therapy 1,106,715
7. Oxygen 0

Subtota 1,106,715
9. Paymer 0
10. Other 0
11. Nurse: 0
12. Gift an 4,807
13. Barber 38,342
14. Non-P 140
15. Telept 112
16. Rental 0
17. Sale o 137,552
18. Sale o 0
19. Labor: 11,352
20. Radiol 1,855
21. Other 35,868
22. Laund 1,045

Subtot 231,073
24. Contril 0
25. Interest 649

Subtot 649
27. Other 3,725
28. Other 0
Subtot 3,725

30. Total F 9,411,369
31. Gener 1,334,250
32. Health 4,410,232
33. Gener 1,982,461
34. Owner 1,613,661
35. Specie 393,655
35. Provid 120,997
37. Other 0
40. Total F 9,855,256
41. Incom: -443,887
42. Incom: 0
43. Net In: -443,887

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9 Line 16 for mortgage insurance.

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